SUMMARY OF THE SYSTEMS REVIEW

General
Fatigue/malaise
Fever/rigors/night sweats
Weight/appetite
Skin: rashes/bruising
Sleep disturbance
CVS
Chest pain
SOB: on exercise/orthopnoea/PND
Palpitation
Ankle swelling
RS
Chest pain
SOB/wheeze
Cough
Sputum/haemoptysis
GIS
Appetite/weight loss
Dysphagia
Nausea/vomiting/haematemesis
Indigestion/heartburn
Jaundice
Abdominal pain
Bowels: change/constipation/diarrhoea/blood/mucus
GUS
Frequency/dysuria/nocturia/polyuria/oliguria
Haematuria
Incontinence/urgency
Prostatic symptoms
Menstruation
   Menarche (age at onset)
   Duration of bleeding, periodicity
   Menorrhagia (blood loss)
   Dysmenorrhoea, dyspareunia
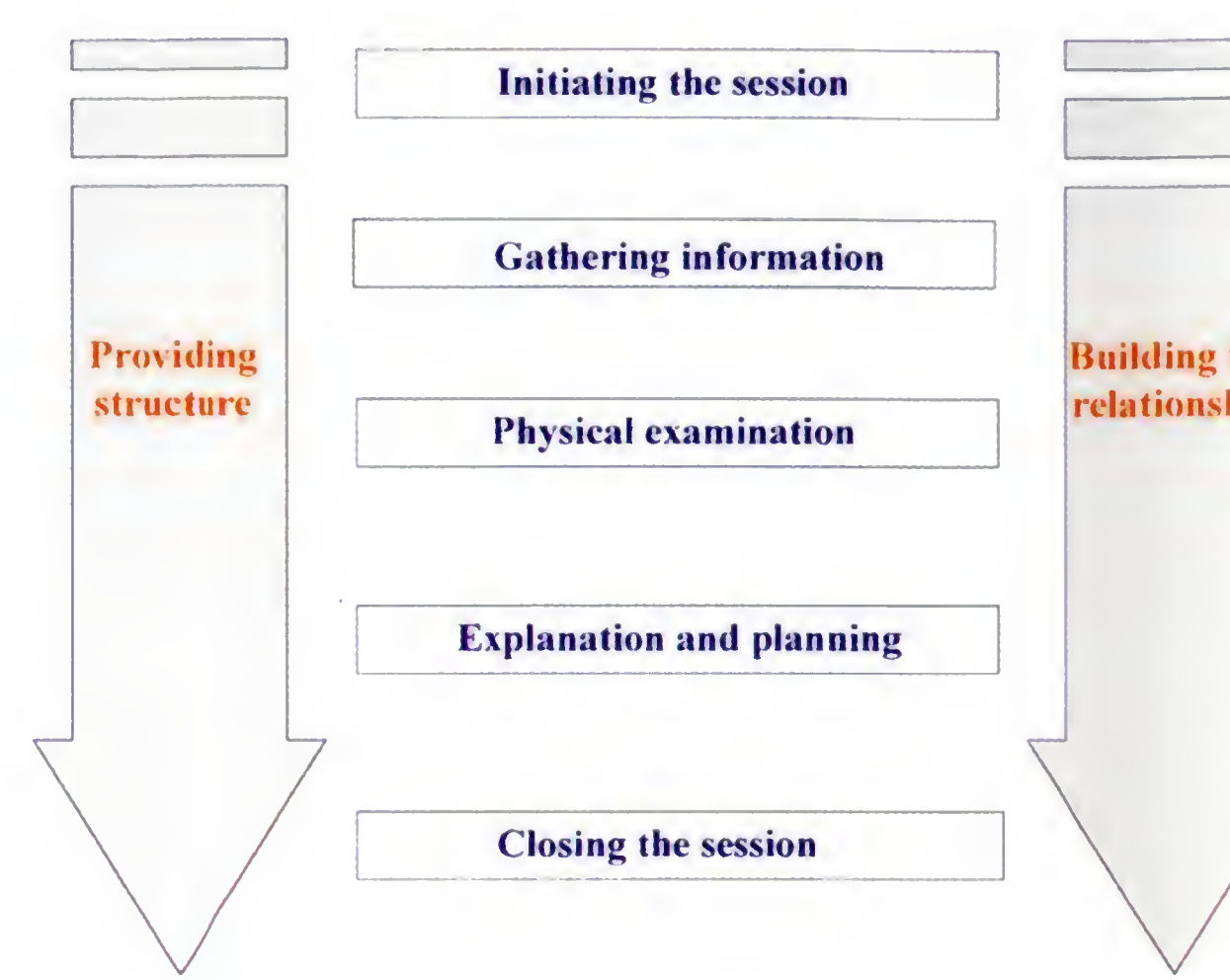   Menopause, post menopausal bleeding
NS
Headache
Fits/faints/loss of consciousness
Dizziness
Vision - acuity, diplopia
Hearing
Weakness
Numbness/tingling
Loss of memory/personality change
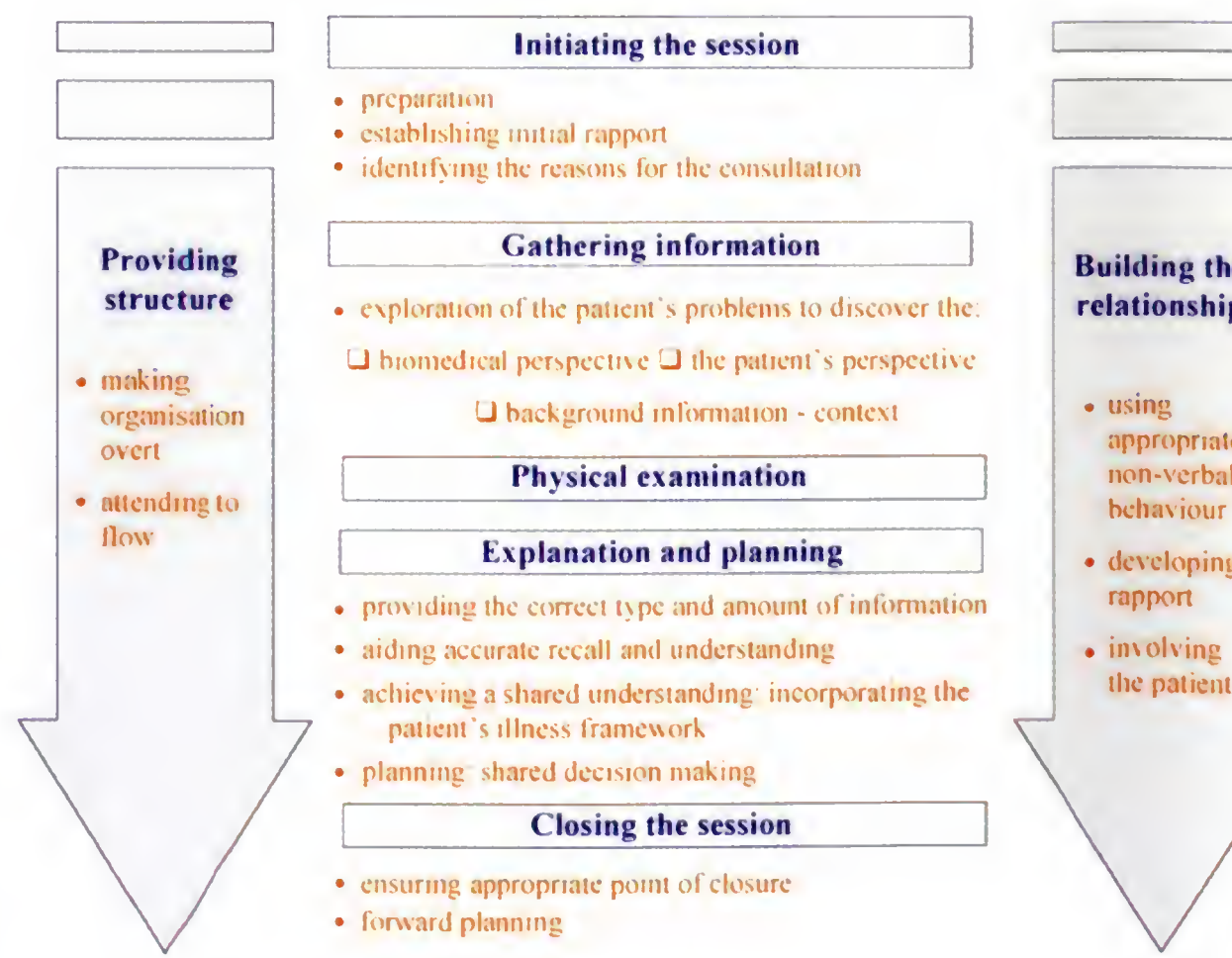Anxiety/depression
Mskel
Pain/swelling/stiffness – muscles/joints/back
Able to wash and dress without difficulty
Able to climb up and down stairs

THE CALGARY-CAMBRIDGE GUIDE TO THE MEDICAL INTERVIEW

The basic framework

Providing structure	Initiating the session	Building relationsh
	Gathering information	
	Physical examination	
	Explanation and planning	
	Closing the session	

The expanded framework

Providing structure	Initiating the session	Building the relationship
• making organisation overt	• preparation • establishing initial rapport • identifying the reasons for the consultation	• using appropriate non-verbal behaviour
• attending to flow	**Gathering information** • exploration of the patient's problems to discover the: ❑ biomedical perspective ❑ the patient's perspective ❑ background information - context	• developing rapport
	Physical examination	
	Explanation and planning • providing the correct type and amount of information • aiding accurate recall and understanding • achieving a shared understanding: incorporating the patient's illness framework • planning: shared decision making	• involving the patient
	Closing the session • ensuring appropriate point of closure • forward planning	

PATIENT'S PROBLEM LIST:

1.
2.
3.
4.

BIOMEDICAL PERSPECTIVE: (DISEASE)
sequence of events

symptom analysis

relevant systems review

PATIENT'S PERSPECTIVE: (ILLNESS)
ideas
concerns
expectations
effects on life
feelings

BACKGROUND INFORMATION - CONTEXT
past medical history

drug and allergy

family history

personal and social history

review of systems

PHYSICAL EXAMINATION

DIFFERENTIAL DIAGNOSIS AND/OR PROBLEM LIST
including both disease and illness issues

PLAN OF MANAGEMENT
investigations; treatment alternatives

EXPLANATION AND PLANNING
what the patient has been told;
plan of action negotiated

INITIATING THE SESSION

Establish initial rapport

Greet patient and obtains patient's name
Introduce self, role and nature of interview; obtain consent
Demonstrate respect and interest, attend to patient's physical comfort

Identify the reason(s) for the consultation

Use appropriate **opening question** to identify problems/issues
Listen attentively to opening statement without interruption
Confirm list and **screen** for further problems
Negotiate agenda

GATHERING INFORMATION

Explore patient's problems

Encourage patient to **tell the story** from when first started
Use **open to closed cone**
Listen attentively
Facilitate patient's responses verbally and non–verbally
Pick up verbal and non–verbal **cues**
Clarify statements
Periodically **summarise**
Use concise, easily understood **language**
Establish **dates**

Understand the patient's perspective

Determine, acknowledge and appropriately explore:
- patient's **ideas** and **concerns**
- patient's **expectations**
- how each problem **affects** the patient's life

Encourage expression of the patient's **feelings**

PROVIDING STRUCTURE TO THE CONSULTATION

Make organisation overt

Summarise at the end of a specific line of inquiry
Signpost next section

Attend to flow

Structure interview in **logical sequence**
Attend to **timing.**

BUILDING THE RELATIONSHIP

Use appropriate non-verbal behaviour

Demonstrate appropriate **non–verbal behaviour:**
- eye contact, facial expression
- posture, position & movement
- vocal cues e.g. rate, volume, tone

If writing **notes,** ensure does not interfere with dialogue or rapport

Develop rapport

Accept patient's views and feelings non-judgementally
Use **empathy**, acknowledge feelings and predicament
Provide **support**
Deal **sensitively** with embarrassing and disturbing topics, pain

Involve the patient

Share thinking with patient
Explain rationale for questions
During **physical examination**, explain process/ask permission

CLOSING THE SESSION

Give any provisional information in clear well organised manner, avoid or explain jargon
Check patient understanding and acceptance of explanation and plans
Encourage patient to discuss any additional points and provide opportunity to do so
Summarise session briefly
Contract with patient re next steps